State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0215	A. BUILDING: _____ B. WING _____	10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER VA BEAC	3750 SENTARA WAY VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/16/19 through 10/18/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 116 licensed bed facility was 88 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 7 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-150 (A) Resident Rights. Cross Reference to F-582. 12VAC5-371-200 (B.1.) Director of Nursing. Cross Reference to F-658. 12VAC5-371-220 (B) Nursing Services. Cross Reference F-658, F-690, F-695 and F-757. 12VAC5-371-250 (A) Resident Assessment and Care Planning. Cross Reference to F-655.	F 001	12VAC5-371-150 (A) Resident Rights. CrossReference to F-582. 12VAC5-371-200 (B.1.) Director of Nursing. Cross Reference to F-658. 12VAC5-371-220 (B) Nursing Services. Cross Reference F-658, F-690, F-695 and F-757. 12VAC5-371-250 (A) Resident Assessment and Care Planning. Cross Reference to F-655.	11/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 11/4

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495270	A. BUILDING _____ B. WING _____	10/18/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/16/19 through 10/18/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/19 through 10/18/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 116 certified bed facility was 88 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 7 closed record reviews	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582	1. No Action taken. Resident #238 and #239 have been discharged with safe transition to the community. 2. Residents receiving Medicare covered skilled services have the potential to be affected. 3. Residents will Medicare covered services will be identified during the daily PPS meeting. A review of the plan	11/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11/4/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 582	Care and anticipated last covered day of services will be reviewed. Residents with anticipated discharge in the next 48 hours will be identified for issuance of notice of the non-Medicare covered services. The social worker will be responsible for issuing the notice of non-Medicare covered services. 4. The Director of Social Services will audit all Medicare discharges daily for 4 weeks to ensure notices are given in a timely manner. A copy of the notice of non-Medicare covered services will be provided to the administrator to monitor for compliance. The results of the audit will be reported to QAPI. 5. Correction Date 11/11/19	

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F 582		F 582		

Continued From page 2

Based on a record review, facility document review and staff interviews the facility staff failed to ensure a Notice of Medicare Non-Coverage was given timely prior to the last covered skilled day for 2 of 39 residents in the survey sample, Resident # 238 and Resident #239.

The findings included:

1. Resident #238 was a 66 year old that was admitted to the facility on 8/22/19 with a diagnosis of Diabetes Mellitus.

Resident #238's Notice of Medicare Non-Coverage was reviewed and is documented in part, as follows:

The Effective Date Coverage of Your Skilled Therapy or Nursing Services Will End: 9/16/19
Resident #238's signed and dated the notice on 9/16/19.

On 10/17/19 at approximately 3:19 P.M. an interview was conducted with the facility Social Worker regarding the Resident #238's Medicare Notices of Non-Coverage and if it was given timely in order for the resident to appeal if so desired. The Social Worker stated, "The Notice of Non-Coverage should be given 48 hours prior to the last covered day. I am new to this position, I only transitioned to this position on 8/5/19. I don't know why they weren't given sooner."

2. Resident #239 was a 94 year old that was admitted to the facility on 8/8/19 with a diagnosis of Diabetes Mellitus.

Resident #239's Notice of Medicare

F 582		F 582		
	Continued From page 3 Non-Coverage was reviewed and is documented in part, as follows: The Effective Date Coverage of Your Skilled Therapy or Nursing Services Will End: 8/21/19 Date: 8/21/19 Time: 11:20 A.M. Spoke to: Name (Resident #239's Son) via phone. On 10/17/19 at approximately 3:19 P.M. an interview was conducted with the facility Social Worker regarding the Resident #239's Medicare Notices of Non-Coverage and if it was given timely in order for the resident to appeal if so desired. The Social Worker stated, "The Notice of Non-Coverage should be given 48 hours prior to the last covered day. I am new to this position, I only transitioned to this position on 8/5/19. I don't know why they weren't given sooner." The facility policy titled "Generic Notice of Medicare Provider Non-Coverage" last revised 8/15/2018 was reviewed and is documented in part, as follows: Policy Statement: Skilled Nursing Facilities must provide the Notice of Medicare Provider Non-Coverage (Generic Notice) to Medicare Beneficiaries No Later than two days (48 hours) before the effective date of the end of the coverage that their Medicare coverage will be ending. On 10/18/19 at 3:47 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided by the facility.			

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F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640	1. Residents #3, #4, and # 5 discharge assessments have been submitted and accepted by CMS 2. Any resident discharged from the facility has the potential to be affected. 3. The Missing Assessment and Suspended report will be run weekly to identify any resident assessments that have not been transmitted. 4. The MDS Coordinator will print the Missing Assessments and Suspended report weekly, dating and time stamping the document. This report will e submitted to the administrator weekly and findings will be reported to QAPI. 5. Correction Date- 11/11/19	11/11/19

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F 640		F 640		
	Continued From page 5 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the facility's Missing Assessment Report, facility document review and staff interviews the facility staff failed to ensure that Discharge Assessments were completed and transmitted timely for 3 of 39 residents in the survey sample, Resident #3, Resident #4 and Resident #5. The findings included: 1. Resident #3 was a 70 year old that was admitted to the facility on 5/1/19 with diagnoses to include but not limited to, Hypertension and Anxiety. On 10/17/19 at 1:51 P.M. the facility's Missing Assessment Report showing late assessments for Resident #3 was reviewed with the facility's traveling MDS (Minimum Data Set) Coordinator. After the MDS Coordinator had time to review and investigate the Missing Assessment Report for the resident the following interview was conducted: On 10/17/19 at 3:51 P.M. the MDS Coordinator stated., "Name (Resident #3's) discharge			

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F 640		F 640		
	Continued From page 6 assessment for 5/14/19 was not completed or transmitted. We have completed it and it has be submitted today. I am not sure how the assessment was missed." The facility's MDS Validation Report dated 10/17/19 was reviewed and is documented in part, as follows: Submit D/C (Discharge) 5/14/2019 Accepted. Assessment Date: 10/17/19 2. Resident #4 is a 94 year old that was admitted to the facility on 5/21/19 with diagnoses to include but not limited to Hypertension and Diabetes Mellitus. On 10/17/19 at 1:51 P.M. the facility's Missing Assessment Report showing late assessments for Resident #4 was reviewed with the facility's traveling MDS (Minimum Data Set) Coordinator. After the MDS Coordinator had time to review and investigate the Missing Assessment Report for the resident the following interview was conducted: On 10/17/19 at 3:51 P.M. the MDS Coordinator stated., "Name (Resident #4's) discharge assessment for 6/10/19 was not completed or transmitted. We have completed it and it has be submitted today. I am not sure how the assessment was missed." The facility's MDS Validation Report dated 10/17/19 was reviewed and is documented in part, as follows: Submit D/C (Discharge) 6/10/2019 Accepted.			

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F 640		F 640		
	Continued From page 7 Assessment Date: 10/17/19 3. Resident #5 was a 70 year old that was admitted to the facility on 11/7/12 with a diagnosis of Peripheral Vascular Disease. On 10/17/19 at 1:51 P.M. the facility's Missing Assessment Report showing late assessments for Resident #5 was reviewed with the facility's traveling MDS (Minimum Data Set) Coordinator. After the MDS Coordinator had time to review and investigate the Missing Assessment Report for the resident the following interview was conducted: On 10/17/19 at 3:51 P.M. the MDS Coordinator stated., "Name (Resident #5's) discharge assessment for 8/30/19 was completed but got transmitted to an insurance company instead of CMS(Center for Medicare and Medicaid Services. It has be submitted today. I am not sure why the assessment was sent to the insurance company instead of CMS." The facility's MDS Validation Report dated 10/17/19 was reviewed and is documented in part, as follows: Submit D/C (Discharge) 8/30/2019 Accepted. Assessment Date: 10/17/19 The facility's Missing Assessment Report was reviewed prior to exit and it was clear of any further missing assessments On 10/18/19 at 3:47 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was			

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F 640	Continued From page 8 shared. Prior to exit no further information was provided by the facility.	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655	1. Resident #288 was discharged home 0n 10/19/19 after a four days stay at the facility. Care plan was collaborated between facility and Hospice. 2. Any resident admitted to the facility has the potential to be affected for the development of baseline care plan. 3. The IDT team will be educated on the development of a baseline care plan for every new admission to the facility. 4. The clinical managers will review all admissions in 48 hours to ensure compliance with the development of a baseline. Findings of the audit will be reported to QAPI. 5. Correction Date 11/11/19.	11/11/19

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F 655		F 655		
	Continued From page 9 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop a baseline care plan for one of 39 residents in the survey sample, Resident #288. The findings include: Resident #88 was admitted to the facility on 10/14/19 with diagnoses that included but were not limited to, Parkinson's Disease, and Alzheimer's Disease. Resident #288's most recent MDS (Minimum Data Set) assessment was an entry assessment with an ARD (assessment reference date) of 10/14/19. Resident #288 did not have a completed comprehensive assessment. Resident #288 was documented in a nursing note dated 10/14/19 as being "pleasantly confused." Review of Resident #288 nursing notes revealed that Resident #288 was admitted to the facility for Respite Care. The following note was documented on 10/14/19: "Received Resident via stretcher...Resident is here for Respite stay until 10/19/19. Resident is alert to self. Pleasantly confused at this time..."			

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F 655		F 655		

Continued From page 10

Further review of Resident #288's clinical record revealed he was also admitted with Hospice Services.

There was no evidence of a baseline care plan for Resident #288.

Further review of Resident #288's clinical record revealed that he had a care plan from his hospice provider. This care plan was not patient centered and did not reflect the care the facility would provide while he was a resident at the facility.

On 10/18/19 at 11:45 a.m., an interview was conducted with RN (Registered Nurse) #3, the unit manager. When asked who was responsible for creating the baseline care plan, RN #3 stated that the nurse doing the admission was also responsible for creating a baseline care plan. When asked when the baseline care plan would be put into place, RN #3 stated that the baseline care plan should be created within 24 hours. When asked what type of areas would be on the baseline care plan, RN #3 stated care areas such as cognitive status, mobility, vision etc. would be on the baseline care plan. When asked if a baseline care plan should be created for every resident admitted to the facility, RN #3 stated that a baseline care plan should be created for every resident. When asked the purpose of the care plan, RN #3 stated that the care plan was a guide on how to care for the patient. When asked if a resident was being admitted to the facility on hospice services, if that would be on the baseline care plan, RN #3 stated that it should be. When asked who has access to the care plan, RN #3 stated all direct care staff had access. When asked if Resident #288 has a baseline care plan, RN #3 stated that Resident #288 was respite and

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F 655	Continued From page 11 that the facility just went by the hospice care plan. When asked if his care plan should reflect the care he is receiving while at the facility, RN #3 stated that it should. When asked if he is admitted to the facility, if the facility is responsible for his care, RN #3 stated that they were. RN #3 confirmed that Resident #288's hospice care plan from the hospice provider did not reflect the care he was to receive while a resident at the facility. When asked if Resident #288's hospice provider had been at the facility for a visit, RN #3 stated that they had and documented services rendered. RN #3 stated that hospice will send a copy of their notes so that it can be scanned into his clinical record. RN #3 stated that hospice also write orders for the facility to implement while he is a resident at the facility. When asked if a hospice care plan should be in place and initiated by the facility to reflect the care the facility was to provide to Resident #288 while he was a current resident, RN #3 stated that the facility usually develops a hospice care plan for all other residents admitted to hospice services. On 10/18/19 at 4 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy regarding care plans did not address the above concerns. Facility policy titled, "Hospice-Guidelines of Care," documented in part, the following: "The plan of care will be based on an assessment of the resident's individual needs and unique living situation while at the facility." No further information was presented prior to exit.	F 655		
F 658	Services Provided Meet Professional Standards	F 658	1. Resident #52 was monitored with no ill effects.	11/11/19

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F 658 SS=D	Continued From page 12 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Medication Administration Record (MAR), the facility failed to administer medications as ordered for 1 of 39 residents in the survey sample, Resident #52. The findings included: Resident #52 was admitted to the facility on 1/14/2019, with a readmission occurring on 8/29/2019 with diagnoses including, but not limited to, chronic systolic (congestive) heart failure, diabetes mellitus with hyperglycemia, and chronic kidney disease. Resident #52's most recent MDS (Minimum Data Set) was a Quarterly review scheduled assessment with an ARD (Assessment Reference Date) of 9/10/2019. Resident #52 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. A review of Resident #52's physician's orders dated 9/4/2019 for the administration of NovoLOG U-100 insulin, aspart 100 unit/ml (milliliter) subcutaneous solution sliding scale insulin (SSI) three times daily, for blood sugar readings greater than 150 read: 150-200 = 1 unit	F 658	2. All Diabetic residents with orders for sliding scale insulin have the potential to be affected. 3. Education will be provided to licensed staff on the 5 rights of medication administration. 4. Observations of administration of sliding scale insulin will be conducted weekly by the Staff educator to monitor compliance with glucose reading and insulin administered. The results of the observations will be reported to QAPI. 5. Correction date- 11/11/19.	

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F 658		F 658		
	Continued From page 13 201-250 = 2 units 251-300 = 3 units 301-350 = 4 units 351-400 = 5 units On 10/17/2019 during a clinical record review it was discovered per the Medication Administration Record (MAR) review, that Resident #52's blood glucose level measured 170 at the 11:30 a.m. reading. The MAR physician's orders prescribed a sliding scale, scheduled order of 1 unit for blood glucose levels of 151-200. The MAR indicated LPN #2 administered 2 units of NovoLOG U-100. A reading of blood sugar level taken at 4:30 p.m. on 10/6/2019 was 208. An interview conducted with Licensed Practical Nurse (LPN) #2 on 10/18/2019 at approximately 12:24 p.m. and asked if the administration of 2 units of NovoLOG U-100 at 11:30 was an error, he responded "Yes, it was an error." When asked what actions should have been taken, he responded, "Notify the family and let the doctor know." On 10/18/2019 at approximately 3:45 p.m., the Director of Nursing was presented with the findings of the administration of 2 units of NovoLOG, in lieu of the prescribed 1 unit. No further information was provided by the facility staff. Facility Policy guiding Medication Administration included: The "RIGHTS" shall be verified prior to EACH administration of EACH medication: "RIGHT RESIDENT "RIGHT DRUG			

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F 658	Continued From page 14 "RIGHT ORDER "RIGHT ROUTE "RIGHT DOSE "RIGHT TIME "RIGHT REASON (indication) "RIGHT to REFUSE "In addition, post administration, the RIGHT DOCUMENTATION should be in place as well as the RIGHT RESPONSE (pain relief, blood glucose lowering, blood pressure lowering, chest pain relief, etc) shall be assessed when appropriate. Subcutaneous Administration: 1. Calculate the correct amount of medication-For correctional insulin orders, validate the blood sugar value corresponds with the correct insulin dose.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690	1. An order for the use of the Foley catheter including size was obtained for resident #55. 2. All residents with catheters have the potential to be affected. 3. All residents with catheters have been checked and have orders for use. New admissions, with catheters will be identified and records reviewed for the presence of orders for catheter use. 4. Clinical Managers will audit all residents admitted with catheters ensure there are appropriate orders. Finding of this audit will be reported to QAPI. 5. Corrective Action Date-11/11/19	11/11/19

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F 690	Continued From page 15 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to obtain an order for the use of a Foley catheter for one of 39 residents in the survey sample, Resident #55. The findings include: Resident #55 was admitted to the facility on 8/2/19 and readmitted on 8/27/19 with diagnoses that included but were not limited to, enlarged prostate and urinary obstruction. Resident #55's most recent MDS (Minimum Data Set assessment) was an admission assessment with an ARD (assessment reference date) of 9/2/19. Resident #55 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #55 was coded in Section H (Bowel and Bladder) as having a urinary catheter.	F 690		

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F 690	Continued From page 16 On 10/16/19 at 12:29 p.m., an observation was made of Resident #55. He was sitting up in his wheelchair with a Foley catheter in place. The catheter collection bag was covered in a dignity bag. Review of Resident #55's October 2019 POS (physician order summary) revealed the following catheter orders: "8/27/19: Urinary Catheter Care one time daily. 8/27/19: Urinary Catheter Care as needed. 8/27/19: Change Catheter every thirty days. 8/27/19: Change Catheter as needed." An order for the use of the Foley catheter including an appropriate diagnosis and size of the catheter could not be found in the clinical record. Review of Resident #55's comprehensive care plan dated 9/9/19 documented the following: "Alteration in bladder elimination R/T (related to) Foley catheter: Elimination will be maintained through indwelling Foley catheter without s/s (signs/symptoms) of UTI (urinary tract infection) through out the next 90 days...Check tubing for kinks several times each shift, Assess resident for pain, discomfort due to catheter. Clean peri-area from front to back. Change indwelling every month or per MD (medical doctor) order. Change drainage bag and tubing every 2 weeks and PRN (as needed). Position catheter bag and tubing below the level of the bladder and keep out of view with use of cover." Further review of Resident #55's clinical record revealed that he was initially admitted to the facility on 8/2/19 with an order for a Foley catheter. This order was discontinued when	F 690		

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F 690		F 690		

Continued From page 17

Resident #55 was transferred to the hospital on 8/9/19. A new order for the use of the Foley catheter was never re-instated.

Further review of Resident 55's admission nursing note dated 8/27/19, revealed that Resident #55 had "16 Fr (french) 10 cc Foley Catheter in place..."

On 10/18/19 at 11:45 a.m., an interview was conducted with RN (Registered Nurse) #3, the unit manager. When asked if an order should be obtained for the use of a Foley catheter, RN #3 stated that there should be an order. When asked what a catheter order usually included, RN #3 stated that a catheter order should include the diagnosis for catheter use and the size of the catheter. When asked how nurses would know what size catheter to use when they need to change the catheter, RN #3 stated that nurses would look at the physician's order. When asked if Resident #55 had an order for his catheter, RN #3 stated that she wasn't sure and would have to check. RN #3 did not return to follow up.

On 10/18/19 at 4 p.m., during the pre exit meeting, ASM (administrative staff member) #2, the Director of Nursing, was made aware of the above concern. ASM #2 stated she would have to check to see if there was an order.

On 10/18/19 at 4:15 p.m., further interview was conducted with ASM #2 and RN # 4, the staff development coordinator. When asked if ASM #2 was able to find a catheter order for Resident #55, ASM #2 presented the above catheter orders for changing every thirty days and catheter care every shift. When asked if there should be an order for the catheter itself, including size of

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F 690	Continued From page 18 the catheter and the diagnosis for use, RN #4 stated, "I see what you are saying." RN #4 presented the admission note dated 8/27/19 documenting the size of the catheter. When asked if there should be an order for the use of the catheter, RN #4 stated that there should be. No further information was presented prior to exit. A policy could not be presented by the facility staff regarding the above concerns.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that facility staff failed to administer oxygen per physician's order for one of 39 residents in the survey sample, Resident #291. The findings include: Resident #291 was admitted to the facility on 10/8/19 with diagnoses that included but not limited to acute respiratory failure, hypoxia and chronic obstructive pulmonary disease. Resident #291's did not have a completed MD'S (minimum data set) assessment.	F 695	1. Resident #291 has been discharged from the facility. 2. Any resident requiring oxygen is at risk to be affected. 3. All residents requiring oxygen therapy will have their orders validated for the administration of oxygen. 4. Charge Nurses will verify during shift rounds that residents are receiving oxygen as ordered. Clinical Managers will audit 25% of residents with oxygen weekly to ensure that residents are receiving oxygen as ordered. Findings will be reported to QAPI. 5. Corrective Action Date 11/11/19	11/11/19

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F 695	Continued From page 19 Review of Resident #291's POS (physician order summary) dated October 2019 documented the following order: "02 (oxygen) at 2 AL (liters) /min (minute) per nasal annular continuously." This order was initiated on 10/8/19. On 10/16/19 at 11:48 a.m., an observation was made of Resident #291. Resident #291 was lying up in bed with his nasal annular in place. His oxygen flow meter was set to 2.5 liters of oxygen. On 10/16/19 at 12:31 p.m., a second observation was made of Resident #291. Resident #291 was lying up in bed with his nasal annular in place. His oxygen concentrator was off. On 10/16/19 at 2:08 p.m., an observation was made of Resident #291. Resident #291 was lying up in bed with his nasal annular in place. His oxygen concentrator was off. When asked Resident #291 how he was breathing, Resident #291 stated he was breathing fine but that sometimes it was difficult because he had emphysema. On 10/16/19 at 2:08 p.m., this writer went to RN (registered nurse) #1, the RN supervisor. RN #1 followed this writer to Resident #291's room. RN #1 turned on Resident #291 concentrator and confirmed it had been off. When RN #1 turned on his concentrator, his flow meter was set to "2.5" liters of oxygen. RN #1 left the room. On 10/16/19 at 2:10 p.m., RN #1 re-entered Resident #291's room and stated that Resident #291 was supposed to be on 2 liters. RN #1 then adjusted Resident #291's flow meter from 2.5 to 2 liters of oxygen.	F 695		

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F 695	Continued From page 20 On 10/18/19 at 4:00 p.m., SAM (administrative staff member) #1, the Administrator and SAM #2, the Director of Nursing were made aware of the above concerns. No further information was provided prior to exit.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Medication Administration Record (MAR), the facility failed to ensure 1 of 39 residents in the survey sample was free from unnecessary	F 757		

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F 757	Continued From page 21 medication, Resident #52. The findings included: Resident #52 was admitted to the facility on 1/14/2019, with a readmission occurring on 8/29/2019 with diagnoses including, but not limited to diabetes mellitus with hyperglycemia, and chronic kidney disease. Resident #52's most recent MDS (Minimum Data Set) was a Quarterly assessment with an ARD (Assessment Reference Date) of 9/10/2019. Resident #52 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. A review of Resident #52's physician's orders dated 9/4/2019 for the administration of NovoLOG U-100 insulin, aspart 100 unit/ml (milliliter) subcutaneous solution sliding scale insulin (SSI) three times daily, for blood sugar readings greater than 150 mg/dL (milligrams per deciliter) read: 150-200 = 1 unit 201-250 = 2 units 251-300 = 3 units 301-350 = 4 units 351-400 = 5 units On 10/17/2019 Resident #52's Medication Administration Record (MAR) was reviewed and revealed that on 10/6/19, Resident #52's blood glucose level measured 170 mg/dL at the 11:30 a.m. reading. The MAR revealed that Licensed Practical Nurse (LPN) #2 administered 2 units of NovoLOG U-100 rather than the 1 unit per physician order. A reading of the blood sugar	F 757	1. Resident # 52 is still residing at the facility and is receiving the sliding scale insulin as ordered. 2. All Diabetic Residents with sliding scale orders have the potential to be affected. 3. Observations of administration of sliding scale insulin will be conducted weekly x 4 weeks by the Staff educator to monitor compliance with glucose reading and insulin administered. Education will be provided to licensed staff on the 5 rights of medication administration. 4. 10% of records with documented coverage of sliding scale will be reviewed by the clinical managers and findings of the audit will be reported to QAPI. 5. Corrective Action Date- 11/11/19.	11/11/19

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F 757	Continued From page 22 level taken at 4:30 p.m. on 10/6/2019 was 208. An interview conducted with LPN #2 on 10/18/2019 at approximately 12:24 p.m. and asked if the administration of 2 units of NovoLOG U-100 at 11:30 was an error, he responded "Yes, it was an error." When asked what actions should have been taken, he responded, "Notify the family and let the doctor know." On 10/18/2019 at approximately 3:45 p.m., the Director of Nursing was presented with the findings of the administration of 2 units of NovoLOG, in lieu of the prescribed 1 unit. No further information was provided by the facility staff. Facility Policy guiding Medication Administration included: The "RIGHTS" shall be verified prior to EACH administration of EACH medication: "RIGHT RESIDENT "RIGHT DRUG "RIGHT ORDER "RIGHT ROUTE "RIGHT DOSE "RIGHT TIME "RIGHT REASON (indication) "RIGHT to REFUSE "In addition, post administration, the RIGHT DOCUMENTATION should be in place as well as the RIGHT RESPONSE (pain relief, blood glucose lowering, blood pressure lowering, chest pain relief, etc) shall be assessed when appropriate. Subcutaneous Administration: 1. Calculate the correct amount of medication-For correctional insulin orders,	F 757		

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F 757	Continued From page 23 validate the blood sugar value corresponds with the correct insulin dose.	F 757		